

Screen Date \_\_\_\_\_

West Virginia Department of Health and Human Resources  
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) HealthCheck Program Preventive Health Screen

11, 12, 13 and 14 Year Form

Name \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_ Sex:  M  F

Weight \_\_\_\_\_ Height \_\_\_\_\_ BMI \_\_\_\_\_ Pulse \_\_\_\_\_ BP \_\_\_\_\_ Resp \_\_\_\_\_ Temp \_\_\_\_\_ Pulse Ox (optional) \_\_\_\_\_

Allergies  NKDA \_\_\_\_\_

Current meds  None \_\_\_\_\_

Foster Child  Child with special health care needs  IEP/section 504 in place \_\_\_\_\_

Accompanied by  Parent  Grandparent  Foster parent  Foster organization \_\_\_\_\_  Other \_\_\_\_\_

**Immunizations:** Attach current immunization record

UTD  Given, see immunization record  Entered into WVSIIS

**Oral Health**

Date of last dental visit \_\_\_\_\_

Current oral health problems \_\_\_\_\_

Water source  Public  Well  Tested

Fluoride supplementation  Yes  No

**Vision Acuity Screen:** (Objective 12 years)

R \_\_\_\_\_ L \_\_\_\_\_

Wears glasses?  Yes  No

**Hearing Screen** (Objective, once between 11 and 14 years)

20db@

R ear: \_\_\_\_\_ 500HZ \_\_\_\_\_ 1000HZ \_\_\_\_\_ 2000HZ \_\_\_\_\_ 4000HZ

L ear: \_\_\_\_\_ 500HZ \_\_\_\_\_ 1000HZ \_\_\_\_\_ 2000HZ \_\_\_\_\_ 4000HZ

R ear: \_\_\_\_\_ 6000HZ \_\_\_\_\_ 8000HZ

L ear: \_\_\_\_\_ 6000HZ \_\_\_\_\_ 8000HZ

Wears hearing aids?  Yes  No

**Developmental Surveillance**

Concerns about behavior, speech, learning, social and/or motor skills \_\_\_\_\_

**Referrals:**

Mental/behavioral health/trauma- **Help4WV.com/1-844-435-7498**

Substance abuse- **Help4WV.com/1-844-435-7498**

Dental  Vision  Hearing

Other \_\_\_\_\_

Family Planning (FP) **1-800-642-9704**

Children with Special HealthCare Needs (CSHCN)

**1-800-642-9704**

\_\_\_\_\_  
**Please Print Name of Facility or Clinician**

\_\_\_\_\_  
**Signature of Clinician/Title**

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**The information above this line is intended to be released to meet school entry requirements**

**Medical History**

Initial Screen  Periodic screen

Recent injuries, surgeries, illnesses, visits to other providers and/or counselors and/or hospitalizations: \_\_\_\_\_

**Family health history reviewed** \_\_\_\_\_

Concerns and/or questions \_\_\_\_\_

**Social/Psychosocial History**

What is your family living situation \_\_\_\_\_

Family relationships  Good  Okay  Poor

Do you have concerns about meeting basic family needs daily and/or monthly (food, housing, heat, etc.)?  Yes  No \_\_\_\_\_

Are parents/caregivers working outside home?  Yes  No

Child care/after school care \_\_\_\_\_

Grade in school \_\_\_\_\_

Favorite subject \_\_\_\_\_

Any problems \_\_\_\_\_

Activities outside school \_\_\_\_\_

Peer relationships/friends  Good  Okay  Poor

How much **stress** are you and your family under **now**?

None  Slight  Moderate  Severe

**What kind of stress?** (✓ Check those that apply)

Relationships (partner, family and/or friends)  School/work

Drugs  Alcohol  Violence/abuse (physical, emotional and/or

sexual)  Family member incarcerated  Lack of support/help

Financial  Emotional loss  Health Insurance

Other \_\_\_\_\_

Concerns and/or questions \_\_\_\_\_

**Traumatic Stress Reactions/PCL-C<sup>1</sup>**

**\*Positive screen = numbered responses 4 or greater**

**Feelings over the past 2 weeks:** (✓ Check one for each question)

Repeated, disturbing memories, thoughts, or images of a

stressful experience from the **past**?  Not at all  A little bit(1)

Moderately(2)  Quite a bit(3)  Extremely(4)

Feeling very upset when something reminded you of a stressful

experience from the **past**?  Not at all  A little bit(1)

Moderately(2)  Quite a bit(3)  Extremely(4)

**Depression Screen/Patient Health Questionnaire (PHQ-2)**

**\*Positive screen = numbered responses 3 or greater**

**\*If Positive see Periodicity Schedule for link to PHQ-9**

**Feelings over the past 2 weeks:** (✓ Check one for each question)

Little interest or pleasure in doing things:  Not at all  Several days(1)

More than ½ the days(2)  Nearly every day(3)

Feeling down, depressed, or hopeless:  Not at all  Several days(1)

More than ½ the days(2)  Nearly every day(3)

**Risk Indicators** (✓ Check those that apply)

None identified  \*Tobacco use  Cigarettes # per day \_\_\_\_\_

E-Cigarettes  \*Chew  Passive Smoke Risk

\*Alcohol use \_\_\_\_\_

\*Drug use (prescription or otherwise) \_\_\_\_\_

**\*If positive see Periodicity Schedule for links to CRAFTT**

**and /or SBIRT screening tools**

Access to firearm(s)/weapon(s)  Has a firearm(s)/weapon(s)

Are the firearm(s)/weapon(s) secured?  Yes  No  NA

Witnessed violence/abuse  Threatened with violence/abuse

Thoughts/plans to harm  Self  Others  Animals  NA

Do you wear protective gear, including seat belts?  Yes  No

**Continue on page 2**

<sup>1</sup>Lang, AG, Stein, M.B. (2005) An abbreviated PTSD checklist for use as a screening instrument in primary care. *Behaviour Research and Therapy*, 43, 585-594. Lang, A. J., Wilkins, K., Roy-Byrne, P. P., Golinelli, D., Chavira, D., Sherbourne, C., Rose, R. D., Bysriksky, A., Sullivan, G., Craske, M. G., & Stein, M. B. (2012). Abbreviated PTSD Checklist (PCL) as a Guide to Clinical Response. *General Hospital Psychiatry*, 34, 332-338. Weathers, F., Litz, B., Herman, D., Huska, J., & Keane, T. (October 1993). The PTSD Checklist (PCL): Reliability, Validity, and Diagnostic Utility. Paper presented at Annual Convention of the International Society for Traumatic Stress Studies, San Antonio, TX.



Name \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_ Sex:  M  F

Excessive television/video game/internet/cell phone use

(13 and 14 years)

Are you in a relationship?  Yes ( Male  Female)  No

Are you sexually active?  Yes  No

Method of contraception \_\_\_\_\_

Do you have children?  Yes  No \_\_\_\_\_

**General Health**

Growth plotted on growth chart

BMI calculated and plotted on BMI chart

**Nutrition/Physical Activity/Sleep**

Normal eating habits?  Yes  No

Fruits/Vegetables/Lean protein per day \_\_\_\_\_

Vitamins \_\_\_\_\_

Normal elimination \_\_\_\_\_

Physical activity/exercise an hour most days

Type of physical activity/exercise \_\_\_\_\_

Normal sleeping patterns?  Yes  No

Hours of sleep each night? \_\_\_\_\_

**\*See Periodicity Schedule for Risk Factors**

**\*Anemia Risk (Hemoglobin/Hematocrit)**

Low risk  High risk

**\*Tuberculosis Risk**

Low risk  High risk

**\*Dyslipidemia Risk**

Low risk  High risk

**Fasting lipoprotein required once between 9 and 11 years**

**\*STI Risk**

Low risk  High risk

**\*HIV Risk**

Low risk  High risk

**Physical Examination (N=Normal, Abn=Abnormal)**

General Appearance  N  Abn \_\_\_\_\_

Skin  N  Abn \_\_\_\_\_

Neurological  N  Abn \_\_\_\_\_

Reflexes  N  Abn \_\_\_\_\_

Head  N  Abn \_\_\_\_\_

Neck  N  Abn \_\_\_\_\_

Eyes  N  Abn \_\_\_\_\_

Ears  N  Abn \_\_\_\_\_

Nose  N  Abn \_\_\_\_\_

Oral Cavity/Throat  N  Abn \_\_\_\_\_

Lung  N  Abn \_\_\_\_\_

Heart  N  Abn \_\_\_\_\_

Pulses  N  Abn \_\_\_\_\_

Abdomen  N  Abn \_\_\_\_\_

**If female:**

LMP \_\_\_\_\_  Regular  Irregular

Bleeding  Normal  Heavy

Cramping  No  Slight  Severe

Genitalia  N  Abn \_\_\_\_\_

Back  N  Abn \_\_\_\_\_

Hips  N  Abn \_\_\_\_\_

Extremities  N  Abn \_\_\_\_\_

**Possible Signs of Abuse**  Yes  No

Concerns and/or questions \_\_\_\_\_

**Anticipatory Guidance**

(Consult Bright Futures, Fourth Edition for further information  
<https://brightfutures.aap.org>)

**Social Determinants of Health**

Interpersonal violence (fighting, bullying)

Living situation and food security

Family substance use (tobacco, E-cigarettes, alcohol, drugs)

Connectedness with family and peers

Connectedness with community

School performance

Coping with stress and decision making

**Physical Health and Health Promotion**

Oral health

Body image

Healthy eating

Physical activity and sleep

**Emotional Well-being**

Mood regulation and mental health

Sexuality

**Risk Reduction**

Pregnancy and sexually transmitted infections

Tobacco, e-cigarettes, alcohol, prescription drugs or street drugs

Acoustic trauma

**Safety**

Seat belt and helmet use

Substance use and riding in a vehicle

Firearm safety

**Other**

**Plan of Care**

**Assessment**  Well Child  Other Diagnosis

**Labs**

Hemoglobin/hematocrit (if high risk)

TB skin test (if high risk)

Fasting lipoprotein (once between 9 and 11 years and/or high risk)

STI test (if sexually active and/or high risk)

HIV test (if sexually active and/or high risk)

Other \_\_\_\_\_

**Referrals**

See page 1, school requirements

**Prior Authorizations**

For treatment plans requiring authorization, please complete page 3. Contact a HealthCheck Regional Program Specialist for assistance at 1-800-642-9704 or [www.dhhr.wv.gov/healthcheck](http://www.dhhr.wv.gov/healthcheck)

**Follow Up/Next Visit**  12 years of age  13 years of age

14 years of age

Other \_\_\_\_\_

**Screen has been reviewed and is complete**

See page 1, school requirements for required signature